

CHICAGO NEUROLOGICAL SOCIETY.

January 18, 1900.

The President, Dr. Richard Dewey, in the Chair.

HEREDITARY CEREBELLAR ATAXIA.

A young man with this affection was shown by Dr. Hugh T. Patrick. The patient was almost eighteen years of age and had developed in a perfectly normal way until the age of fourteen. He had attended the public schools where his progress had been satisfactory, and he had then taken a position as messenger and general utility boy in a store where his services were also satisfactory. The first symptom to appear was clumsiness of the legs, and this was soon followed by a gradual change in disposition and some impairment of memory. From this time there had been gradual mental and physical failure until mentally the condition was almost one of imbecility, and physically the patient was quite incapacitated for any employment. He walked with a wide, uncertain gait, the pupils were slightly irregular and did not react to light and not perfectly to accommodation. Speech was rather slow, somewhat indistinct and inco-ordinate, and accompanied by over-action of the facial muscles. The deep reflexes were all exaggerated with the exception of the jaw jerk, which could not be obtained.

An elder brother had died at the age of twenty-one of a similar disease, which began when he was about fifteen years old.

AN ETIOLOGIC STUDY OF NEUROSES OF PERIPHERAL ORIGIN.

Dr. H. Gradle read a paper with this title, objecting to the name "reflex neuroses" as inappropriate; the speaker classified under the head of neuroses of peripheral origin those nervous disturbances, sensory or motor, which are maintained by some peripheral anomaly, and which cease when the peripheral cause is removed. As examples, he quoted headache and migraine due to ocular defects or to nasal disease, the neuralgias due to disease of the accessory sinuses or disease of the teeth, the asthma of nasal origin, the laryngeal spasm of pharyngeal origin. Epileptoid convulsions are sometimes, but very rarely, of reflex origin. The symptoms of exophthalmic goiter have been observed a few times as a nasal neurosis. Chorea of the eyelids are probably the result often of chronic conjunctivitis, although this is not positive. According to the speaker's experience they are not due to refractive errors. Neurasthenia is not a neurosis of peripheral origin in any case; on the contrary, it is the underlying basis of many instances of such neuroses. When a peripheral source of annoyance is re-

moved the neurasthenic manifestations are of course benefited.

The fact that errors of refraction usually cause in healthy people merely fatigue and blurring of the eyes, but in certain patients bring on disturbing nervous symptoms, can only mean that in the latter instance other factors are involved as well as the eye-strain. These influences predisposing to neuroses of peripheral origin can often be ascertained from the patient's history, but not always. They were enumerated and described in detail under the heads of "heredity," "insufficient nutrition during the nursing period," "want of outdoor exercise and inactivity of muscles," "loss of sleep," "mental worry," in short, unhygienic surroundings. Anemia is a very frequent determining condition. Disturbances of the intestines sometimes seem to predispose to ocular neuroses, and occasionally such neuroses persist on a psychic basis after the intestinal disturbance has disappeared. The gist of the paper was to the effect that the concurrence of various factors was necessary in the production of neuroses of peripheral origin, as well as the existence of a peripheral anomaly, and that these, hence, should also receive due attention.

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- 78 INSUFFISANCE NASALE HYSTERIQUE (Hysterical Nasal Insufficiency). Marcel Lermoyez (La Presse médicale, Jan. 25, 1899, p. 37).

The patient, a young girl, had had in childhood complete obstruction of the nasal fossa, as a result of hypertrophy of the inferior turbinated bones. This was relieved, and although the nasal cavities were completely clear, she was utterly unable to respire through them, and if the mouth were held forcibly closed, rapidly manifested signs of asphyxia. There was no spasm of the palatal muscles which closed the anterior fossa of the nose; in fact, the air passages were completely free. Although the patient had never had any crises or other of the ordinary manifestations of hysteria, she was carefully examined for stigmata, with the result of finding complete anesthesia to all forms of sensation over the whole body, and extreme concentric refraction of the field of vision, with preservation of the normal pupillary reactions; complete loss of taste and smell, and loss of ability to perceive sound by bone conduction. There were no hysterogenic areas, and no emotional manifestations. The patient was, in fact, of a gay and active disposition. It was now found that the mere pretense of closing the mouth when the lips were held sufficiently separated to allow the passage of air produced a cyanosis as profound as that produced by complete closure of the mouth. The patient was observed during sleep, and it was found that the nasal breathing was perfectly normal, the mouth remaining closed. Lermoyez explains the case as probably the result of an auto-suggestion at the time of operation, that nasal breathing would be impossible, it being his belief that the effort to breath by the nose required a synergy of muscular effort that could only be carried out by sustained attention and will-power, and that of both of these the hysterical patient was incapable. SAILER.